Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10300

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 82 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 215 Franklin St.

3. NAME OF DECEASED (Type or Print): (First) Barbara (Middle) (Last) Ackerman

4. DATE OF DEATH: (Month) 11 (Day) 28 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Mar 4 1867

9. AGE last birthday: 82 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Allegany Co., Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Schmidt

14. MOTHER'S MAIDEN NAME: Magdalene Schellhaus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Katherine E. Schmidt, Married

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174 Immediate cause (a) Carcinoma of the uterus — Interval between onset and death: 1 yr.

Antecedent cause(s)

480 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 11, 1949, to Nov 28, 1949, that I last saw the deceased alive on Nov 28, 1949, and that death occurred at 1:25 P.m., from the causes and on the date stated above.

SIGNATURE: H. V. Deming M.D. (Degree or title) — ADDRESS: Cumberland Md — DATE SIGNED: Nov 29-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Dec 1 49 — NAME OF CEMETERY OR CREMATORY: St Peter & Pauls Cem — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Nov. 30, 1949 — REGISTRAR'S SIGNATURE: Walter R. Lantz, M.D.

24. FUNERAL DIRECTOR: Long Stein Inc. — ADDRESS: Cumberland

RECEIVED
DEC 3 1949
BUREAU V. S.

Gattens

10301

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location): 101 Spring St.

3. NAME OF DECEASED (Type or Print)	(First) ARTHUR	(Middle) MILBURN	(Last) ALEXANDER	4. DATE OF DEATH (Month) Nov. (Day) 28, (Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: 10-9-1880	9. AGE last birthday: 69 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired miner	10b. KIND OF BUSINESS OR INDUSTRY: coal mines	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Alexander		14. MOTHER'S MAIDEN NAME: ELizabeth Loar		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 214-01-6703	17. INFORMANT: Mrs. Raymond Baer		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

151 Immediate cause (a) Carcinoma of Stomach — 1 yr.

Antecedent cause(s)

46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Nephritis — 1 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 26, 1949, to Nov. 28, 1949, that I last saw the deceased alive on Nov. 28, 1949, and that death occurred at 6.00 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W E Gattens	M.D.	Frostburg Md.	11/30/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Dec. 1, 1949	NAME OF CEMETERY OR CREMATORY: Allegany Cemetery	LOCATION (City, town, or county) (State): Frostburg, Md.
DATE REC'D BY LOCAL REG.: 12-1-49	REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe	24. FUNERAL DIRECTOR: J. R. Durst,	ADDRESS: Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 6 1949
BUREAU V. S.

Within corporate limits DR. GROVE

10302

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 3-DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WESTERNPORT
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) (Last) BARNARD

4. DATE OF DEATH (Month) NOV. (Day) 19 (Year) 1949

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH MARCH 26 1871
9. AGE last birthday 78 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER AND MANAGER
10b. KIND OF BUSINESS OR INDUSTRY GENERAL INS. CO.
11. BIRTHPLACE (State or foreign country) PENNsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME NATHANIEL BARNARD
14. MOTHER'S MAIDEN NAME NANCY SPIER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary thrombosis	3 days
422.1 Antecedent cause(s)	Mesenteric thrombosis	3 days
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic cardio-	
	(c) vascular disease	10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Intestinal obstruction

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-16, 1949, to 11-19, 1949, that I last saw the deceased alive on 11-19, 1949 and that death occurred at 8:45A m., from the causes and on the date stated above.

SIGNATURE D. G. Irving (Degree or title) MD ADDRESS Cumberland Md DATE SIGNED 11-21-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Nov. 22, 1949
NAME OF CEMETERY OR CREMATORY Philos Cemetery
LOCATION (City, town, or county) Westernport (State) Md

DATE REC'D BY LOCAL REG. Nov. 21, 1949
REGISTRAR'S SIGNATURE D. G. Irving M.D. Winter R. Frantz - J.
24. FUNERAL DIRECTOR C. J. Boal ADDRESS Westernport, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 29 1949
BUREAU V. S.

Within corporate limits

10303

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 22 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 138 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 138 Bedford St.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Elizabeth (Last) Barnes
4. DATE OF DEATH (Month) Nov (Day) 20 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Sept 6 1874
9. AGE last birthday 75 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Midland Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Craze
14. MOTHER'S MAIDEN NAME Mary Van Buskirk
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Ap (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS James W. Stevenson. Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	16 hours
331 Antecedent cause(s)		
830 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis. Hypertension.	Unk
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 15, 1949, to Nov 20, 1949, that I last saw the deceased alive on Nov 20, 1949, and that death occurred at 4:50 A.m., from the causes and on the date stated above. 11/21/49

SIGNATURE J. H. Matthews. (Degree or title) M.D. ADDRESS 140 Bedford St Cumberland DATE SIGNED Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Nov 22 49
NAME OF CEMETERY OR CREMATORY Old Coney Cem.
LOCATION (City, town, or county) Lonaconing (State) Md

DATE REC'D BY LOCAL REG. Nov. 22, 1949
REGISTRAR'S SIGNATURE Winter R. Hartz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

3

I

Dr Matthai

Within corporate limits

10304

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 14 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 301 Beall St.

3. NAME OF DECEASED (Type or Print) (First) Nellie (Middle) Palmer (Last) Bloss
4. DATE OF DEATH (Month) Nov. (Day) 29 (Year) 1949
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH July31-1879
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY --
11. BIRTHPLACE (State or foreign country) Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Peter Cowden
14. MOTHER'S MAIDEN NAME Sarah Pitzer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Henry W. Bloss

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary (right lung) embolism due to a — 12 days

900.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) deep contusion of right chest & arm.

186a

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes & hypertention — ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
(CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Nov.17/49-P. 3.30 m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Fell down stairs at home.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Nov. 30-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12-2-1949
NAME OF CEMETERY OR CREMATORY HillCrest Burial Park
LOCATION (City, town, or county) Cumberland, Md. (State)
DATE REC'D BY LOCAL REG. Dec. 2, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumbeerland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 3 1949
BUREAU V. S.

Within corporate limits: ~~DR. HODGES~~ Dr. Eliason

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10305

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, LENGTH OF STAY (in this place) 27 DAYS	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 315 MARYLAND AVENUE

3. NAME OF DECEASED (Type or Print)	(First) RONALD	(Middle) R.	(Last) BORST	4. DATE OF DEATH	(Month) NOV. (Day) 25, (Year) 1949
5. SEX Male	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH OCT. 15, 1949	9. AGE last birthday yrs.	If under 1 year: Months 1, Days 10; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? NSA.	
13. FATHER'S NAME WILLIAM R. BORST			14. MOTHER'S MAIDEN NAME DEBORAH N. BUGG		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None		17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL- CUMBERLAND, MD.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Malnutrition	8 wks
756.0 Antecedent cause(s)		
157g Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pyloric Stenosis	8 wks.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Nov. 1. 1949	19b. MAJOR FINDINGS OF OPERATION Pyloric Stenosis	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-25, 1949, to 11.25, 1949, that I last saw the deceased alive on 11.25, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H W Eliason Md.		126 Union St.	Cumberland Md

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/27/1949	Bron Memorial Burial Park	Cumberland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 27, 1949	Winter R. Frantz, M.D.	William H. Kight,	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Kight Funeral Home

1454

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10306

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STREET ADDRESS (If rural, give location): Railroad Street

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) Buckel (Last) Boyd

4. DATE OF DEATH: (Month) 11 (Day) 6 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 13, 1868

9. AGE last birthday: 80 yrs. — If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pekin, Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. R. W. Smith, Allegany County Infirmary

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval between onset and death: 4 hrs

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) General Arteriosclerosis — 5 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 28, 1949, to Nov. 6, 1949, that I last saw the deceased alive on Nov. 4, 1949, and that death occurred at 9:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M.D. 110 S. Centre St. Nov. 7, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Nov. 8th 1949 — NAME OF CEMETERY OR CREMATORY: Old Coney Cemetery — LOCATION (City, town, or county) (State): Lonaconing Md.

DATE REC'D BY LOCAL REG.: Nov. 8, 1949 — REGISTRAR'S SIGNATURE: Winter R. Kantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: M. Eichhorn, Lonaconing Md.

10307

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) All her life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 27 Linden St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Mildred Biddington Boyer

4. DATE OF DEATH (Month) (Day) (Year) Nov. 5th, 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Dec. 19, 1878
9. AGE last birthday 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Mylson Biddington
14. MOTHER'S MAIDEN NAME Ellenora Atkinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Earl Boyer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
155 Immediate cause	(a) Primary Carcinoma gallbladder	2 months
46f Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Abscess gallbladder wall.	1 wk.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus. — 2 years

19a. DATE OF OPERATION November 5, 1949
19b. MAJOR FINDINGS OF OPERATION Primary Carcinoma Gallbladder c̄ abscess of gallbladder wall
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/29, 1947, to 11/5, 1949, that I last saw the deceased alive on 11/5, 1949, and that death occurred at 2 48 P. m., from the causes and on the date stated above.

SIGNATURE Hilda Jane Walters, Md. (Degree or title) ADDRESS Frostburg, Md. DATE SIGNED 11/7/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 11-8-49
NAME OF CEMETERY OR CREMATORY Allegany
LOCATION (City, town, or county) Frostburg, (State) Maryland.

DATE REC'D BY LOCAL REG. 11-8-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Joseph R. Durst ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 15 1949
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

10308

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; LENGTH OF STAY (in this place) 45 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Louis (Last) Bridges

4. DATE OF DEATH: (Month) 11 (Day) 7 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug 7-1863

9. AGE last birthday: 86 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carmen

10b. KIND OF BUSINESS OR INDUSTRY: C. & P. R.R. Co

11. BIRTHPLACE (State or foreign country): Beans Cove Pa.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mr. Marshall Bogard Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Prostate — Interval Between Onset and Death: ?

177

Antecedent cause(s)

51b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-7-, 1948, to ....., 19....., that I last saw the deceased alive on 11-2-, 1949, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Dwight L. Wilson - M.D. Cumberland, Md. 11-8-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 11-9-1949

NAME OF CEMETERY OR CREMATORY: St Patrick's Cem.

LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: NOV - 11 - 49

REGISTRAR'S SIGNATURE: Veronica McDermitt

24. FUNERAL DIRECTOR / ADDRESS: Jacob Hafer

RECEIVED
JUL 14 1949
U.S.

Within corporate limits

W.F.WMS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10309

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 9 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ~~ALLEGANY~~ Garrett; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ACCIDENT MD; STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) Cormans (Middle) Garfield (Last) BROBST

4. DATE OF DEATH: (Month) NOV. (Day) 16 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: JULY 24, 1880

9. AGE last birthday: 69 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM BROBST

14. MOTHER'S MAIDEN NAME: LAVINA TISH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 1 wk.

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-7, 19 49 to 11-16, 19 49, that I last saw the deceased alive on 11-16, 19 49 and that death occurred at 7:20 p.m. from the causes and on the date stated above.

SIGNATURE W. F. Wilson (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 11-18-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Nov 19-1949 | NAME OF CEMETERY OR CREMATORY: Accident Cemetery | LOCATION (City, town, or county) (State): Accident, Maryland

DATE REC'D BY LOCAL REG.: Nov. 18, 1949 | REGISTRAR'S SIGNATURE: Walter L. Mantz, M.D. | 24. FUNERAL DIRECTOR: Emroy Bolden | ADDRESS: Oakland Md

RECEIVED
NOV 22 1949
BUREAU OF U. S.

Within corporate limits

10310

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 30yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 443 Pennsylvania Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 443 Pennsylvania Ave.

3. NAME OF DECEASED (Type or Print): (First) Rose Lee (Middle) Butts (Last)

4. DATE OF DEATH: (Month) (Day) (Year) 11/19/49 19

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 3/5/1882

9. AGE last birthday: 67 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): near Fort Ashby W.Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mose McKenzie

14. MOTHER'S MAIDEN NAME: Mary Brewer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Harry B. Butts

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171 Immediate cause (a) Carcinoma Cervix with generalized metastasis — Interval Between Onset and Death: 1½ years

Antecedent cause(s)

48a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 July, 1949 to 19 Nov., 1949, that I last saw the deceased alive on 18 Nov., 1949 and that death occurred at 7.2A m., from the causes and on the date stated above.

SIGNATURE: W. Alfred Vance (Degree or title) — ADDRESS: Cumberland, Md. — DATE SIGNED: 20 Nov. 49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 11/21/49 — NAME OF CEMETERY OR CREMATORY: Greenmount Cem — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. Nov. 20, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.

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NOV 29 1949
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Within corporate limits DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

CB 10311 Reg. Dist. No. 4

M C I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AF5

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
LENGTH OF STAY (in this place): 3mons. 8days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: PENN. COUNTY: BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: HYNDMAN, PENN.
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Kenneth ~~BABY~~ (Middle) Franklin ~~BOY~~ (Last) BYERS

4. DATE OF DEATH: (Month) 11 (Day) 17 (Year) 49

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): INFANT

8. DATE OF BIRTH: SEPT. 12 1949

9. AGE last birthday: yrs. If under 1 year: Months 2 Days 5; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: WILLIAM BYER

14. MOTHER'S MAIDEN NAME: HILDA ~~BYERS~~ Benna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) *Meningo-encephalitis	2mo.
751 **Antecedent cause(s)**		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
157c	(c) Hydrocoele	2mo 5days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Sept. 12 1949, to Nov. 17 1949, that I last saw the deceased alive on 11/17, 1949, and that death occurred at 10:08P m., from the causes and on the date stated above.

SIGNATURE: John A Topper (Degree or title): MD ADDRESS: Hyndman Pa. DATE SIGNED: 11/18/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: 11/19/49 NAME OF CEMETERY OR CREMATORY: Tatesville, Pa. LOCATION (City, town, or county) (State): Tatesville, Pa.

DATE REC'D BY LOCAL REG.: Nov. 18, 1949 REGISTRAR'S SIGNATURE: Wynter K. Krantz, M.D.

24. FUNERAL DIRECTOR: Harvey H. Zeigler ADDRESS: Hyndman, Pa.

RECEIVED
NOV 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10312

CERTIFICATE OF DEATH

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Savage Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Alice (Middle) Edith (Last) Click

4. DATE OF DEATH: (Month) 11 (Day) 4 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Oct. 1-1923

9. AGE last birthday: 26 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Work

10b. KIND OF BUSINESS OR INDUSTRY: Celanese

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Alexander Click

14. MOTHER'S MAIDEN NAME: Mary Baxter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Mrs. Florence Layton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Tuberculosis	12 mos
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-15, 1949, to 11-3, 1949, that I last saw the deceased alive on 11-3, 1949, and that death occurred at 4:05 A m., from the causes and on the date stated above. Nov. 5 1949

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED
Ralph W. Ballin | M.D. | 62 Greene St. Cumberland Md

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 11-7-1949 | NAME OF CEMETERY OR CREMATORY: St. Patricks Cem | LOCATION (City, town, or county): Mt. Savage, | (State): Md.

DATE RECD BY LOCAL REG. 11-6-49 | REGISTRAR'S SIGNATURE: Vernon McDermott | 24. FUNERAL DIRECTOR: Jacob Hafer | ADDRESS: Md.

Ballin

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10313

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 326 Crawford Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 326 Crawford Street

3. NAME OF DECEASED (Type or Print): (First) Lena (Middle) L (Last) Cline

4. DATE OF DEATH: (Month) November (Day) 15 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: July 13 1869

9. AGE last birthday: 80 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: House

11. BIRTHPLACE (State or foreign country): Yellow Springs, W. Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: [illegible] Secrist David Giffen

14. MOTHER'S MAIDEN NAME: [illegible] Marguerite Secrist

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Geo Arbogast, 326 Crawford St Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	4 wks
Antecedent cause(s)		
422.2 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	2 yrs
	(c) Senility	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 22, 1949, to Nov. 14, 1949, that I last saw the deceased alive on Nov. 14, 1949, and that death occurred at 10:35 a.m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones — (Degree or title): M.D. — ADDRESS: 116 S. Centre St. — DATE SIGNED: Nov. 15, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Nov 18/49 — NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Nov. 17, 1949 — REGISTRAR'S SIGNATURE: Wirster L. Lantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

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NOV 22 1919
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10314

Reg. Dist. No. 17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cresaptown — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Potomac Park

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cresaptown
STREET ADDRESS (If rural, give location) Potomac Park

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRANK	LEE	CLYMER	Nov. 24, 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours. Min.
Male	White	Widowed	Sept. 29, 1860	89 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Medical Doctor	Woodstock, Va.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Clymer	Ella Givens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No	None	Frank Lee Clymer Potomac Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Terminal Bronchial Pneumonia — 1 week

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) Senility & Generalized arteriosclerosis — ?

450.0 107

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 27 Sept 49, 19..., to 24 Nov. 49, 19..., that I last saw the deceased alive on 1 Nov. 49, 19..., and that death occurred at 5:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. Alfred Va Clymer

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 26. 1949	Elmwood Cem.	Shepherdstown, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Nov. 26, 1949	W. Alfred Va Clymer	Charles L. George Cumberland, Md.

RECEIVED
JAN 2 1950
BUREAU V. S.

10315

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton
LENGTH OF STAY (in this place) 74 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Agnes (Middle) Veronica (Last) Comer
4. DATE OF DEATH (Month) Nov. (Day) 16 (Year) 1949
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH Aug. 28-1875
9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Barton Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Comer
14. MOTHER'S MAIDEN NAME Bridgett O' Conners
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ----
17. INFORMANT Winfred Conners

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
901.0 Immediate cause	(a) Coronary thrombous due to	about
186a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) fractured right leg.	20 min.
	(c) Arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
(CITY OR TOWN) Barton (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) Oct. (Day) 25 (Year) 1949 (Hour) 2:15 P.m.
INJURY OCCURRED While at work ☒ Not while at work ☐
HOW DID INJURY OCCUR? Fell from stepladder, papering wall

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V. Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Nov. 16-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 19, 1949
NAME OF CEMETERY OR CREMATORY St. Gabriels Cemetery
LOCATION (City, town, or county) Barton, Allegany Co (State) Md
DATE REC'D BY LOCAL REG. 11/19/49
REGISTRAR'S SIGNATURE [illegible] M.D.
24. FUNERAL DIRECTOR Ellsworth S. Boal ADDRESS Western Part Maryland

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
NOV 21 1960

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10316

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 5 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 311 Bedford St

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 311 Bedford St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Vizard	Cookerly	Nov	3	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	Nov 10, 1880	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Contractor	Md.	U.S.

13. FATHER'S NAME: John Cookerly
14. MOTHER'S MAIDEN NAME: Agnes — Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	217-14-4610	John H. Clark - R#3 - Cumb Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	Few minutes
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chr myocarditis	7 years
93d	(c) Arterial hypertension	7 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1949 to Nov 3, 1949, that I last saw the deceased alive on Nov 3, 1949, and that death occurred at 10:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
R.W. Treaskis Jr	Cumberland, Maryland	11/5/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 5, 1949	Rose Hill Cemetery	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Nov. 5, 1949	Winter R. Frantz, M.D.	John F. Hafer Cumberland Md

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BUREAU V. S.

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10317

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, | LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND, COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 507 MARYLAND AVE.,

3. NAME OF DECEASED (Type or Print): (First) BABY GIRL (Middle) (Last) CUNNINGHAM

4. DATE OF DEATH: (Month) 11 (Day) 21 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE

8. DATE OF BIRTH: NOV. 20/49

9. AGE last birthday: yrs. | If under 1 year: Months | Days 1 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DONALD O. CUNNINGHAM

14. MOTHER'S MAIDEN NAME: ANITA SHUMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity — Interval between onset and death: 24 hr

762.5 Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) atelectasis — 24 Hrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 20, 1949 to Nov. 21, 1949, that I last saw the deceased alive on Nov. 21, 1949, and that death occurred at 5:50 P. m. from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm. Hodges — ADDRESS Cumberland, Md. — DATE SIGNED 11/21/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE 11-22-1949 | NAME OF CEMETERY OR CREMATORY Zion Memorial | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Nov 22, 1949 | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS Cumberland, Md.

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Within corporate limits

DR. WHITWORTH

10318

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near CUMBERLAND, Rural
STREET ADDRESS (If rural, give location) RT. #2, BALTIMORE PIKE

3. NAME OF DECEASED (Type or Print) (First) THELMA (Middle) T. (Last) DARR

4. DATE OF DEATH (Month) NOV. (Day) 9 (Year) 1949

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH APRIL 28 1901

9. AGE last birthday 48 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (State or foreign country) Higganasville W. Va

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME EVAN LEE HENDERSON

14. MOTHER'S MAIDEN NAME LEOTA McCULLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) —

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinomatosis Generalized.

171

Antecedent cause(s)

48a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Adeno-Carcinoma Cervix

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1948, to 9 Nov, 1949, that I last saw the deceased alive on 9 Nov, 1949, and that death occurred at 10 15 A m., from the causes and on the date stated above.

SIGNATURE Fuller B. Whitworth (Degree or title) MD. ADDRESS Cumberland DATE SIGNED MD

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Nov. 12, 49

NAME OF CEMETERY OR CREMATORY Baptist Cem.

LOCATION (City, town, or county) (State) 3 Churches W. Va

DATE REC'D BY LOCAL REG. Nov. 12, 1949

REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.

24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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NOV 15 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10319

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) ~~Furnace Street~~ 125 Front St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Elizabeth	Ross	Davis	11	5	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	Widow	Unknown	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? Yes.

13. FATHER'S NAME James O. Ross
14. MOTHER'S MAIDEN NAME Margaret Guy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Brother - Chas. E. Ross

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	1 wk
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	1 yr
	(c) Senility	

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 28, 1949, to Nov 5, 1949, that I last saw the deceased alive on Nov. 4, 1949, and that death occurred at 9:00 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Nov. 7, 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov 8, 1949	Phila. Cemetery	Western Port	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 7, 1949	Verner R. Hartz M.D.	Ellsworth & Boal	Western Port Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

City Hall

15 1949
BUREAU V. B.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10320

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Dr Fred Ulms

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH COUNTY Allegany — MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland LENGTH OF STAY (in this place) 23 yrs HOSPITAL OR INSTITUTION OR STREET ADDRESS 707 Hill Top Drive	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md — COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland STREET ADDRESS (If rural, give location) 707 Hill Top Drive

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Ruth	Elizabeth	Deremer	Nov	7	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	White	Single	July 29 1906	43 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Crystal Laundry	Keyser W. Va	U.S

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George E. Deremer	Elizabeth McKean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	214-05-7001	Geo E. Deremer 707 Hill Top Drive

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	2 days
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 11-6-, 1949, to 11-7-, 1949, that I last saw the deceased alive on 11-7-, 1949, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. F. Williams	M.D.	Cumberland	11-9-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov 10, 1949	Hillcrest Cemetery	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 10, 1949	Walter K. Frantz, M.D.	John J. Hafer,	Cumberland Md

Mr Styles.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10321

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE W. Va. COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft. Ashby
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hosp.	STREET ADDRESS (If rural, give location) Immediate vicinity ✓

3. NAME OF DECEASED (Type or Print)	(First) SARAH	(Middle) ELMIRE	(Last) DEREMER	4. DATE OF DEATH	(Month) Nov. (Day) 3, (Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 27, 1888	9. AGE last birthday 61 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Mlo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Short Gap, W. Va.	12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME H. S. Daniels	14. MOTHER'S MAIDEN NAME Susan Gates				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Charles Deremer Ft. Ashby, W. Va.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac Vascular	June
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Renal Disease	15-49
	(c)	

442

131 a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-15-, 1949, to 11-3-, 1949, that I last saw the deceased alive on 11-3-, 1949, and that death occurred at 6:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. L. Williams M.D. ADDRESS Cumberland Md. DATE SIGNED 11-5-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Nov. 6, 1949	NAME OF CEMETERY OR CREMATORY Ft. Ashby Cem.	LOCATION (City, town, or county) Ft. Ashby, W. Va. (State)
DATE REC'D BY LOCAL REG. Nov. 5, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz M.D.	24. FUNERAL DIRECTOR Charles L. George Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
NOV 8 1949
BUREAU OF U. S.

Within corporate limits DR. ROBINSON

10322

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 3-DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN OAKLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 7th ST.

3. NAME OF DECEASED (Type or Print)	(First) SHELIA	(Middle) D.	(Last) DE WITT	4. DATE OF DEATH	(Month) NOV. (Day) 27 (Year) 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) INFANT	8. DATE OF BIRTH JUNE 8 1949	9. AGE last birthday yrs.	If under 1 year Months 5 Days 19; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GUY DE WITT			14. MOTHER'S MAIDEN NAME WILMA BELL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Memorial Hospital		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pneumonia, broncho l & r lungs — 4 days

491 Antecedent cause(s)

107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/24, 1949, to 11/27, 1949, that I last saw the deceased alive on 11/27, 1949, and that death occurred at 11:40P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Thomas Robinson	M. D.	19 South Liberty St. Cumberland, Md.	11/29/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 29 1949	Oakland Cemetery	Oakland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 29, 1949	Winta R. Krantz, M.D.	Emroy Bolden	Oakland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 3 1949
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10323

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH · COUNTY Allegany · MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mc Coole | LENGTH OF STAY (in this place) 1 Yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md. · COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mc Coole-Rural
STREET ADDRESS (If rural, give location) ¼ Mi. East Mc Coole

3. NAME OF DECEASED (Type or Print) (First) Andrew (Middle) — (Last) Di Ubaldo
4. DATE OF DEATH (Month) Nov. (Day) 5 (Year) 19 49

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower | 8. DATE OF BIRTH May 5, 1883 | 9. AGE last birthday 66 yrs. | If under 1 year Months 8 | Days | If under 24 hrs. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer | 10b. KIND OF BUSINESS OR INDUSTRY Lake Paper Mill | 11. BIRTHPLACE (State or foreign country) Italy | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-09-7980
17. INFORMANT Arnona Di Ubaldo

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary Occlusion — Interval Between Onset and Death: At once

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Coronary sclerosis — ?
(c) Arteriosclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertention — 3 Yr.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. V. Deming M.D. H. V. Deming M.D.		Cumberland Md.	Nov 5-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 8, 1949	St. Peters Cemetery	Western Port, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov 8/49	[illegible]	Ellsworth S. Boal	Western Port, Md.

RECEIVED
NOV 10 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

10324

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (In this place): in route to
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: W.Va. — COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Short Gap
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Margaret		Dyer	Nov.	14	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	married	April 23-1908	41 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Lainsville W.Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Opha Teter	Texia Stump

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	--	------	Virgil K. Dyer

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
331	Immediate cause	(a) Cerebral Hemorrhage (apoplexy)	about 10 minutes
83a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
		(c) Hypertention (marked)	about 8 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.		Cumberland Md.	Nov.14-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 17 1949	Fort Ashby Cemetery	Fort Ashby, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 17 1949	Hunter K. Mantz, M.D.	Charles L. George	Cumberland, Md

VS. A15A

RECEIVED
NOV 22 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10325

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 4 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 21 Pennslyvania Ave	STREET ADDRESS (If rural, give location): 21 Pennslyvania Avenue

3. NAME OF DECEASED (Type or Print)	(First) Lou	(Middle) H.	(Last) Ellis	4. DATE OF DEATH	(Month) November (Day) 2 (Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Jan 10 1865	9. AGE last birthday: 84 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY: Farming	11. BIRTHPLACE (State or foreign country): Newburg, West Virginia	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME: Joseph R. Ellis	14. MOTHER'S MAIDEN NAME: Heneretta Tetlo				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT AND ADDRESS: John E. Woodyard, 21 Penna Ave, Cumberland Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Metastatic Carcinoma	1 yr. 6 pp.
Antecedent cause(s)	(b) Carcinoma Stomach	1 yr. 6 pp.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

151

46 b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/9, 1948 to 10/31, 1949, that I last saw the deceased alive on 10/31, 1949, and that death occurred at 3 A m., from the causes and on the date stated above.

SIGNATURE: A. T. Yes (Degree or title) ADDRESS: 404 Decatur St Cumberland Md. DATE SIGNED: 11/8/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Nov 5 1949	NAME OF CEMETERY OR CREMATORY: Knights Of Pythias Cem	LOCATION (City, town, or county) (State): Newburg, West Virginia
DATE REC'D BY LOCAL REG.: Nov 4, 1949	REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.	24. FUNERAL DIRECTOR: William H. Kight, Cumberland,	ADDRESS: Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

RECEIVED
NOV 8 1949
BUREAU V. R

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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10326

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 10 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 7 N. Grant St

3. NAME OF DECEASED (Type or Print) (First) Lottie (Middle) Elizabeth (Last) Engle
4. DATE OF DEATH (Month) 11 (Day) 9 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Oct 24-1888
9. AGE last birthday 61 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Boston Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jefferson Norrell
14. MOTHER'S MAIDEN NAME Harriet Moore
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Mr Elmer Engle

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) cachexia	1 month
171 Antecedent cause(s)		
480a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cancer of Cervix uteri	18 month
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from September, 1949, to Nov. 9, 1949, that I last saw the deceased alive on Nov 8, 1949, and that death occurred at 1:30 a. m., from the causes and on the date stated above.

SIGNATURE Adolph Wolferman (Degree or title) M.D. ADDRESS Frostburg DATE SIGNED 11-9-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 11-11-1949
NAME OF CEMETERY OR CREMATORY Allegany Cem.
LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. 11-11-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg

Wolferman

RECEIVED
NOV 15 1949
BUREAU V. S.

Within corporate limits DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

10327

1. PLACE OF DEATH — COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 2 HRS. 45 MI.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): 1319 VIRGINIA AVE.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOHN	Robert	ESTES	NOV.	6	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
MALE	WHITE	MARRIED	JULY 8, 1883	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired machinist helper	10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R.Co.	11. BIRTHPLACE (State or foreign country): [redacted] Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: [redacted] John Estes		14. MOTHER'S MAIDEN NAME: VIRGINIA GUEST	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 705-05-4985	17. INFORMANT AND ADDRESS: Mrs. Jessie Estes, Cumberland, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 2 hrs

Antecedent cause(s) (b) Hypertensive Arteriosclerotic

443 83d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) C.M.D. — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) Cumberland	(COUNTY) Alleg. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1/15/46, 19....., to 11/6/49, 19....., that I last saw the deceased alive on 11/6/49, 19....., and that death occurred at 10 55 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. J. Williams	M.D.	Cumberland Md	11/7/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov. 9, 1949	Hillcrest Burial Park	Cumberland,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 9, 1949	Winter R. Frantz M.D.	John J. Hofer	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

10328

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport. LENGTH OF STAY (in this place) Native	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location) Wood Street.

3. NAME OF DECEASED (Type or Print)	(First) Elizabeth	(Middle) Grant	(Last) Flanagan.	4. DATE OF DEATH	(Month) Nov. (Day) 3, (Year) 1949. 19
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 12, 1868.	9. AGE last birthday 81 yrs.	If under 1 year Months 5 Days 21 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Westernport, Maryland.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Patrick A. Grant.	14. MOTHER'S MAIDEN NAME Rose Louth.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Rose Flanagan.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
490 Immediate cause	(a) Lobar Pneumonia (Cause of death)	4 days.
108 Antecedent cause(s) other conditions Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardiovascular Disease	1 yr.
	(c) death congestive heart failure.	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1949, to Nov 3, 1949, that I last saw the deceased alive on Nov 3, 1949, and that death occurred at 11 30 9 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James H Wolverton Jr	MD	Piedmont W. Va	Nov 7, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 11-7-49.	NAME OF CEMETERY OR CREMATORY St. Peters	LOCATION (City, town, or county) (State) Westernport, Md.
DATE REC'D BY LOCAL REG. Nov. 7/49	REGISTRAR'S SIGNATURE [illegible] MD	24. FUNERAL DIRECTOR W. Harold Fredlock Jr	ADDRESS Piedmont, W.Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 10 1949
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10329

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) rear 236 Oldtown Rd.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) J. (Last) Fresh

4. DATE OF DEATH: (Month) November (Day) 5 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: July 9, 1871

9. AGE last birthday: 78 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner, Retired

10b. KIND OF BUSINESS OR INDUSTRY: Coal

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George H. Fresh

14. MOTHER'S MAIDEN NAME: Lucy Hager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Lillian McKenney - 914 Gay St. Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

199.1 **Immediate cause** (a) Sarcoma - neck. Type undetermined — Interval Between Onset and Death: 1 yr.

Antecedent cause(s)

55e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 16, 1949, to Nov. 5, 1949, that I last saw the deceased alive on Nov. 4, 1949, and that death occurred at 9:55 A.m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED

Arthur T. Jones M. D. | 110 S. Centre St. | Nov. 7, 1949

23. BURIAL, CREMATION REMOVAL, (Specify): Burial | DATE: Nov. 7, 1949 | NAME OF CEMETERY OR CREMATORY: Old Coney Cemetery | LOCATION (City, town, or county) (State): Lonaconing Md.

DATE REC'D BY LOCAL REG.: Nov. 7, 1949 | REGISTRAR'S SIGNATURE: Winter R. Dantz M.D. | 24. FUNERAL DIRECTOR: John J. Hafer, Cumberland, Md. | ADDRESS

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OCT 10 1949
BUREAU U. S.

Within corporate limits

DR. SIMONS 10:45

Call 27 [illegible]

10330

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 10 HRS 30 MI.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 756 CLEVELAND AVE.

3. NAME OF DECEASED (Type or Print) (First) GRACE (Middle) L. FRIDINGER (Last)

4. DATE OF DEATH (Month) NOV. (Day) 11 (Year) 1949

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): INFANT
8. DATE OF BIRTH: DEC. 16 1948
9. AGE last birthday: yrs. — If under 1 year: Months 10, Days 20 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRIDINGER, WILLIAM T.
14. MOTHER'S MAIDEN NAME: McCRACKEN, LOUISE B.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: William T. Fridinger, O.S.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

500 Immediate cause (a) Tracheo bronchitis, acute — 16 hrs

Antecedent cause(s)

106 C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/11, 1949, to 11/11, 1949, that I last saw the deceased alive on 11/11, 1949, and that death occurred at 10:30 A m., from the causes and on the date stated above.

SIGNATURE: George M Simons M.D. (Degree or title) ADDRESS: 128 Union St Cumberland Md DATE SIGNED: 11/11/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Nov. 13, 1949
NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.
LOCATION (City, town, or county): Cumberland (State): Md

DATE REC'D BY LOCAL REG.: Nov. 13, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein, Inc., Cumberland, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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DEC 22 1949
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10331

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. M5

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; MARYLAND; LENGTH OF STAY (in this place) 5 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart; STREET ADDRESS (If rural, give location) Cortis Road

3. NAME OF DECEASED (Type or Print): (First) Charles; (Middle) Kenneth; (Last) Fraley

4. DATE OF DEATH: (Month) 11; (Day) 17; (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child

8. DATE OF BIRTH: 5-11-1943

9. AGE last birthday: 6 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Miners Hospital Frostburg Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Fraley

14. MOTHER'S MAIDEN NAME: Alice Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No; (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Robert Fraley, Eckhart, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Degenerative Brain Disease	2 mos.
Antecedent cause(s)		at least
237		?? - 6 mos.
57d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Probable Brain Tumor	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): None m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 20, 1949, to Nov. 17, 1949, that I last saw the deceased alive on Nov. 17, 1949, and that death occurred at 10:30 P.m., from the causes and on the date stated above.

SIGNATURE: Martin Rothstein (Degree or title) M.D. ADDRESS: 48 Broadway - Frostburg, Md. DATE SIGNED: 11/18/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE: 11-20-49; NAME OF CEMETERY OR CREMATORY: Allegany Mem.; LOCATION (City, town, or county): Frostburg; (State) Md

DATE REC'D BY LOCAL REG. 11-20-49; REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe

24. FUNERAL DIRECTOR: Jacob Hafer; ADDRESS: Frostburg, Md

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Within corporate limits

DR. W. F. WMS.

65

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10332

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND; COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; LENGTH OF STAY (in this place): 10 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): 101 GRAND AVE.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	HARVEY	H	GARLITZ	NOV.	29	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	NOV. 5 1885	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	MERCHANT	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE GARLITZ	MARY ~~NEWMAN~~ Newman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	—	George Garlitz – Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis Myocardial Infarction	10 days.
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Arteriosclerosis.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 3-21, 1930, to 11-29, 1949, that I last saw the deceased alive on 11-28, 1949, and that death occurred at 1:35 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. F. Williams	M. D.	Cumberland	11-30-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Dec. 1, 1949	Hillcrest Burial Park	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 1, 1949	Wister R. Frantz, M.D.	John J. Hafer	Cumberland, Md.

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DEC 3 1949
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10333

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 4 HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS ALLEGANY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE DISTRICT OF COLUMBIA — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WASHINGTON
STREET ADDRESS (If rural, give location) 203 F Street, N. W.

3. NAME OF DECEASED (Type or Print): (First) ~~BABY~~ ~~BOY~~ (Middle) GILBERT (Last) Robert Gilbert Jr.

4. DATE OF DEATH: (Month) Nov (Day) 8 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: Nov. 8, 1949

9. AGE last birthday: X yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours 6 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: ROBERT CARROLL GILBERT

14. MOTHER'S MAIDEN NAME: GERALDINE HOEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: R. C. Gilbert, WASHINGTON, D. C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Respiratory Failure — 773.5

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity — 159

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Nov, 1949, to ....., 19....., that I last saw the deceased alive on 8 Nov, 1949, and that death occurred at 10:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Leland A Rawson MD — 63 Greene ST, Cumberland — 8 Nov 49

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL | DATE: NOV. 9, 1949 | NAME OF CEMETERY OR CREMATORY: HAMILL CEMETERY | LOCATION (City, town, or county) (State): KITZMILLER, MARYLAND

DATE REC'D BY LOCAL REG.: Nov. 9, 1949 | REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: WILLIAM H. KIGHT — CUMBERLAND, MD.

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NOV 10 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10334

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary	STREET ADDRESS (If rural, give location) 19 Arch Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lola	Elizabeth	Grayson	11	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
F	W	Single	Nov. 3. 1859	90 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper		Antioch, W.Va.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin Grayson	Catherine Michael

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		None	Miss Josephine Patrick. Westernport, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Congestive heart failure	1 wk.
450.0 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General arteriosclerosis	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug 23, 1949, to Nov. 19, 1949, that I last saw the deceased alive on Nov. 15, 1949, and that death occurred at 2:10 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Nov. 19, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov. 21 1949	Hillcrest Burial Park	Cumberland.	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 21, 1949	Winter R. Frantz, M.D.	Louis Stein, Inc.	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

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NOV 29 1949
BUREAU V. S.

Within corporate limits

10335

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN in ambulance in route to
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Districk of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington ~~D.C.~~ (20)
STREET ADDRESS (If rural, give location) 1430 S.St.Southeast

3. NAME OF DECEASED (Type or Print) (First) Claudia (Middle) C. (Last) Hall
4. DATE OF DEATH (Month) Nov. (Day) 11 (Year) 1949
5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Nov 25.1888
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Rochelle Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George F.Nasworthy
14. MOTHER'S MAIDEN NAME Amanda Wendham
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Husband-George A. Hall

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
819.5 Immediate cause	(a) Intracranial hemorrhage due to a	about 3
170 C Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) fractured skull from automobile accident	hours
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY highway route 50
(CITY OR TOWN) Near Erwin (COUNTY) (STATE) W.Va.
TIME OF INJURY (Month) (Day) (Year) (Hour) Nov.11/49 3.10 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Decending Cheat Mt. brakes burned out, unable to make a sharp turn and hit trees.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Nov.12-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 19, 1949
NAME OF CEMETERY OR CREMATORY Primitive Baptist Cemetery
LOCATION (City, town, or county) Pierson (State) Tlas
DATE REC'D BY LOCAL REG. Nov. 15, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

10336

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke — LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Franklin
HOSPITAL OR INSTITUTION OR STREET ADDRESS Luke Pulp & PaperCo.Plant	STREET ADDRESS (If rural give location) R.F.D.#1 Westernport Md.Box 23

3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) Alexander	(Last) Hamilton Jr.	4. DATE OF DEATH	(Month) Nov.	(Day) 27	(Year) 1949
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH May 16-1909	9. AGE last birthday 40 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tankman in beater room	10b. KIND OF BUSINESS OR INDUSTRY Mfg.of Paper	11. BIRTHPLACE (State or foreign country) Rural) Franklin Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William A. Hamilton	14. MOTHER'S MAIDEN NAME Amanda Randalls						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 232-01-1208	17. INFORMANT Oneida Sigler Hamilton					

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis (marked)	?
	(c) Cardiac hypertrophy	

420.1
94a

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H.V. Deming M.D.	Cumberland Md.	Nov.27-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Nov. 30, 49	NAME OF CEMETERY OR CREMATORY Philos Cem	LOCATION (City, town, or county) Westernport (State) Md
DATE REC'D BY LOCAL REG. Nov. 30/49	REGISTRAR'S SIGNATURE [illegible] M.D.	24. FUNERAL DIRECTOR E. Ellsworth S. Boal	ADDRESS Westernport, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 1 1949
BUREAU V.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10337

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
~~CITY~~ (If outside corporate limits, write RURAL and give nearest town) OR TOWN Potomac Park Near Cumberland Rural
STREET ADDRESS (If rural, give location) R F D #6

3. NAME OF DECEASED (Type or Print) (First) Samuel (Middle) Reese (Last) Hendrickson
4. DATE OF DEATH (Month) Nov (Day) 9 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Sept 28 1896
9. AGE last birthday 53 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver
10b. KIND OF BUSINESS OR INDUSTRY Oil Truck.
11. BIRTHPLACE (State or foreign country) Cumberland Valley, Pa
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Harvey Hendrickson
14. MOTHER'S MAIDEN NAME Hattie Boor.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-8597
17. INFORMANT AND ADDRESS Ed. R. Hendrickson, Potomac Park Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
541.0	Immediate cause	(a) Gastric Hemorrhage	2 hrs.
	Antecedent cause(s)	(b) Obstructing Duodenal	~~May~~ April 1946
117a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) and marginal ulcers	Sept 21, 1949

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Osteomyelitis Left femur

19a. DATE OF OPERATION 11/2/49 & 11/7/49
19b. MAJOR FINDINGS OF OPERATION Obstruction & ulcer formation following Gastro-Enterostomy Apr. 15, 1946
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1946 to Nov. 9, 1949, that I last saw the deceased alive on Nov. 9, 1949, and that death occurred at 12:30 P m., from the causes and on the date stated above.

SIGNATURE James P. Halleman (Degree or title) M.D. ADDRESS 1 Zoo Decatur St. Cumberland Md. DATE SIGNED 11/11/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Nov. 12, 1949
NAME OF CEMETERY OR CREMATORY Hillcrest Cem.
LOCATION (City, town, or county) Cumberland, (State) Maryland
DATE REC'D BY LOCAL REG. Nov. 12, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

Dr Rozum.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

10338

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Co. Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 443 Goethe St.

3. NAME OF DECEASED (Type or Print): (First) Ralph (Middle) (Last) Hill

4. DATE OF DEATH: (Month) Nov. (Day) 28 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Jan. 2-1874

9. AGE last birthday: 75 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired master mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Footer's Dye Works-Allegany Co. Md.

11. BIRTHPLACE (State or foreign country): U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Hill

14. MOTHER'S MAIDEN NAME: Emily Puntsford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-7098

17. INFORMANT: Ida May Hill

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Subdural hematoma due to a — 51 days

900.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the under ying cause last 186a (b) fracture of the skull.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home

(CITY OR TOWN): Cumberland (COUNTY): Allegany (STATE): Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY: Oct. 8/49-3.30 P. m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Fell backward down cellar stairs.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. Nov. 29-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 12-1-1949

NAME OF CEMETERY OR CREMATORY: Trinity Luthern

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Nov. 30, 1949

REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

VS. A15A

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DEC 3 1949
BUREAU V. S.

DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10339

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 4 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: FRIENDSVILLE, MD.
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) BABY (Middle) GIRL (Last) HINKLEY

4. DATE OF DEATH: (Month) NOV. (Day) 7 (Year) 19 49

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: NOV. 7, 1949

9. AGE last birthday: yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours 4 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MEMORIAL HOSPITAL, Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HINKLEY, RONALD

14. MOTHER'S MAIDEN NAME: ELIZABETH WINNIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No

(If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Prematurity (6 months)

776 Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b):

(c):

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 10:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Fuller B. Whitworth M.D. **ADDRESS**: Cumberland Md. **DATE SIGNED**:

23. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

DATE: NOV. 9, 1949

NAME OF CEMETERY OR CREMATORY: MEMORIAL HOSPITAL

LOCATION (City, town, or county) (State): CUMBERLAND, ALLEG. MD.

DATE REC'D BY LOCAL REG.: Nov. 9, 1949

REGISTRAR'S SIGNATURE: Lester L. Hantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: Memorial Hospital, Cumberland, Md.

RECEIVED
NOV 15 1949
BUREAU V. S.

Within corporate limits

10340

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 713 St. Mary's Ave.

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Howard (Last) Hipsley

4. DATE OF DEATH: (Month) 11 (Day) 28 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: Oct. 1, 1900

9. AGE last birthday: 49 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R. Co.

11. BIRTHPLACE (State or foreign country): Berkeley, W.Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Howard Hipsley

14. MOTHER'S MAIDEN NAME: Alice Fellers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: 710-09-7338

17. INFORMANT AND ADDRESS: Mrs Maudie A. Hipsley 713 St Marys Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Carcinoma — Interval between onset and death: about 10 months

Antecedent cause(s)

193
546

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 3, 1949, to Nov 28, 1949, that I last saw the deceased alive on Nov 27, 1949, and that death occurred at 4:55 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H. V. Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: 11-28-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 11/30/49 — NAME OF CEMETERY OR CREMATORY: St. Luke Cem — LOCATION (City, town, or county) (State): Cumberland, Md

DATE REC'D BY LOCAL REG.: Nov. 29, 1949 — REGISTRAR'S SIGNATURE: Wm. K. Hantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: James J. Scarpelli, Cumberland, Maryland

RECEIVED
DEC 3 1949
BUREAU V. S.

Within corporate limits DR. W.F.WMS.

10341

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 4 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 6 Marion St.

3. NAME OF DECEASED (Type or Print)	(First) FLORA	(Middle) A	(Last) JENKINS	4. DATE OF DEATH	(Month) 11/6 (Day) (Year) 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH June 3 1881	9. AGE last birthday 68 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN ASH			14. MOTHER'S MAIDEN NAME TRessie BEnnett		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Memorial Hospital, Cumberland, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchogenic Carcinoma — Unknown

162

Antecedent cause(s)

47C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-19-49, 1949, to 11/6/, 1949, that I last saw the deceased alive on 11/6/, 1949, and that death occurred at 11:46 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm. J. Williams M.D. — ADDRESS Cumberland — DATE SIGNED 11-7-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 9, 1949	Hillcrest Burial Park	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 9, 1949	Winter R. Frantz, M.D.	John J. Hofer, Cumberland, Md.	

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Hofer

Hallinan

10342

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barrelsville; STATE MARYLAND; LENGTH OF STAY (in this place) 29 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt 1 Hyndman Pa

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barrelsville; STREET ADDRESS (If rural, give location) Rt 1 Hyndman Pa.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) (Last) Johns.

4. DATE OF DEATH: (Month) Nov (Day) 13 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov 27, 1882

9. AGE last birthday: 66 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Trucker

10b. KIND OF BUSINESS OR INDUSTRY: Self Owned.

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Angelo Johns

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Frank Johns, Barrelsville Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcenoma of the Stomach — Interval Between Onset and Death: 8 mo.

Antecedent cause(s) (b) Cachexia — 2 mo.

151 / 46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 7, 49, to Nov. 13, 49, that I last saw the deceased alive on Nov. 13, 49, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James P. Hallinan M.D.; 300 Decatur St, Cumberland Md. 11/15/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Nov 17, 1949 — NAME OF CEMETERY OR CREMATORY: Coolbaugh Cemetery — LOCATION (City, town, or county) (State): Near Barrelsville Md

DATE REC'D BY LOCAL REG.: Nov. 15, 1949 — REGISTRAR'S SIGNATURE: Mrs. J. Lloyd Wright

24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland, Md

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NOV 17 1949
BUREAU, V. C.

10343

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Edward (Last) Kabrick
4. DATE OF DEATH (Month) Nov (Day) 2 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Sept 16, 1872
9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) West Virgina
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs James Thrasher

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Congestive

Immediate cause (a) Acute Cardiac failure

332 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Thrombosis

83b (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Oct, 1949, to 2 Nov, 1949, that I last saw the deceased alive on 2 Nov, 1949, and that death occurred at 9 20 A m., from the causes and on the date stated above.

SIGNATURE John B. Davis, MD (Degree or title) ADDRESS Frostburg Md DATE SIGNED 11/3/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 4, 1949
NAME OF CEMETERY OR CREMATORY Family Home Buring Ground
LOCATION (City, town, or county) Antioch, W.Va. (State)
DATE REC'D BY LOCAL REG. 11-3-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR M. Eichhorn ADDRESS Lonaconing, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 9 - 1939
BUREAU V. A.

10344

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Church St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) Church St

3. NAME OF DECEASED (Type or Print) (First) Emma (Middle) Lowe (Last) Kimmell

4. DATE OF DEATH (Month) Nov. (Day) 6 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH June 23, 1860
9. AGE last birthday 89 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife
10b. KIND OF BUSINESS OR INDUSTRY own
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Lloyd L. Lowe
14. MOTHER'S MAIDEN NAME Nancy Ritner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT R. E. Kimmell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic	10 Years
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senility	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Coronary Thrombosis — 3 Years

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 19, 1946, to Nov. 6, 1949, that I last saw the deceased alive on Nov. 5, 1949, and that death occurred at 2:15 A m., from the causes and on the date stated above.

SIGNATURE Paul B. Wilson (Degree or title) M.D. ADDRESS Piedmont, W. Va. DATE SIGNED Nov. 8, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 8-49
NAME OF CEMETERY OR CREMATORY Philos Cemetery
LOCATION (City, town, or county) Westernport, Alle. (State) Md

DATE REC'D BY LOCAL REG. Nov. 8/49
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR W. Harold Fredlock ADDRESS Piedmont, W. Va

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 10 1949
BUREAU V. S.

Within corporate limits

M

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10345

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland Md. — LENGTH OF STAY (in this place): 50yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: II5 Race St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland Md.
STREET ADDRESS (If rural, give location): II5 Race St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Catherine C. King
4. DATE OF DEATH (Month) (Day) (Year): II/I6/49 19

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: II/29/I872
9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Westernport, Md.
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: William McCamley
14. MOTHER'S MAIDEN NAME: Bridget Norton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Raphael King II5 Race St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
331	Immediate cause	(a) Cerebral Haemorrhage	2 days
	Antecedent cause(s)		
83a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	5 yrs
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1949, to Nov. 16, 1949, that I last saw the deceased alive on Nov. 16, 1949, and that death occurred at 3:10 P. m., from the causes and on the date stated above.

SIGNATURE: Clay J. Jurrett — (Degree or title): M.D. — ADDRESS: Cumberland — DATE SIGNED: 11/17/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: II/I9/49 — NAME OF CEMETERY OR CREMATORY: St. Patrick's Cem — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Nov. 18, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.

RECEIVED
NOV 22 1949
BUREAU V. S.

Within corporate limits

DR. DAUGHERTY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10346

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE Maryland; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 3 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital Cumberland, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE West Virginia; COUNTY Grant; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bayard; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Carl; (Middle) F; (Last) Layman

4. DATE OF DEATH: (Month) Nov. (Day) 5 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Sept. 4 1948

9. AGE last birthday: 1 yrs. If under 1 year: Months 2; Days 1; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred C. Layman

14. MOTHER'S MAIDEN NAME: Clarice L. Willis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No; (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

517 Immediate cause (a) Asphyxia — Laryngeal Edema — Interval between onset and death: 5 days.

Antecedent cause(s)

105 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Atelectasis Left Lung —

(c) Main stem bronchus occlusion

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 11-5-49 — 19b. MAJOR FINDINGS OF OPERATION: Laryngeal Edema - Foc tree filled & fluid

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 2, 1949, to Nov 5, 1949; that I last saw the deceased alive on Nov 5, 1949, and that death occurred at 7:50 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Lester E Daugherty — ADDRESS: Cumberland Maryland — DATE SIGNED: 11-5-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 11-6-49 — NAME OF CEMETERY OR CREMATORY: Bayard Cemetery — LOCATION (City, town, or county) (State): Bayard Grant W. Va

DATE REC'D BY LOCAL REG.: Nov. 6, 1949 — REGISTRAR'S SIGNATURE: Winter K. Kantz, M.D. — 24. FUNERAL DIRECTOR: Kenneth A. Waite — ADDRESS: Cumberland, Md.

RECEIVED
JUL 15 1989
BUREAU V. S.

Outside of City Limits

10347

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland.
LENGTH OF STAY (in this place): 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: RFD #2 Williams Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland (Rural)
STREET ADDRESS (If rural, give location): Rt #2 Williams Rd.

3. NAME OF DECEASED (Type or Print): (First) Jacob (Middle) Mc Clennen (Last) Lewis
4. DATE OF DEATH: (Month) Nov (Day) 21 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb 27 1872
9. AGE last birthday: 77 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R. R. Carman
10b. KIND OF BUSINESS OR INDUSTRY: R.R. Retired 12 yrs.
11. BIRTHPLACE (State or foreign country): Petersburg, Ot Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Lewis
14. MOTHER'S MAIDEN NAME: Rebecca Boar.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Ev. (If year, give war or dates of service) —
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Dolan Lewis R.F.D. #2 Cumb'd Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

151 Immediate cause (a) Ca of Stomach — 6 mo

Antecedent cause(s) —

46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐ —
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 11/5/49, 19....., to 11/20/49, 19....., that I last saw the deceased alive on 11/20/49, 19....., and that death occurred at 11 p m., from the causes and on the date stated above.

SIGNATURE: H Williams (Degree or title) MD. ADDRESS: Cumberland Md DATE SIGNED: 11/21/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 11-23-49
NAME OF CEMETERY OR CREMATORY: Mt. Herman Cem.
LOCATION (City, town, or county): Rural Cumberland (State) Md
DATE REC'D BY LOCAL REG.: Nov. 23, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc ADDRESS: Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10348

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: md COUNTY: allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location): So. Water

3. NAME OF DECEASED (Type or Print): Sharon (First) Baby (Middle) Marie Girl (Last) Lewis

4. DATE OF DEATH (Month) Nov. (Day) 8 (Year) 1949

5. SEX: F

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 11-8-49

9. AGE last birthday: 1 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours 2 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John F. Lewis

14. MOTHER'S MAIDEN NAME: Betty House

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: John F. Lewis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
773.5 Immediate cause	(a) Prematurity, Anoxia,	1 hour
Antecedent cause(s)		
159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hydramnios a. nephritis of mother	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-8, 1949, to 11-8, 1949, that I last saw the deceased alive on 11-8, 1949, and that death occurred at 11 30 a.m., from the causes and on the date stated above.

SIGNATURE: Adolf Wolfermann (Degree or title) M.D. — ADDRESS: Frostburg — DATE SIGNED: 11-9-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 11-9-49 — NAME OF CEMETERY OR CREMATORY: allegany — LOCATION (City, town, or county): Frostburg (State): md

DATE REC'D BY LOCAL REG.: 11-9-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy J. Roe

24. FUNERAL DIRECTOR: J. R. Durst — ADDRESS:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

NOV 15 1949
BUREAU OF

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10349

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
MARYLAND
LENGTH OF STAY (in this place): 24 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: —

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STREET ADDRESS (If rural, give location): Charlestown St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Annie	Miller	Llewellyn	Nov.	6	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	July 16, 1864	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own Home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
S. J. Miller	Emily Jane Wilt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
—	—	Mrs Haines Lonaconing Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Broncho-pneumonia (terminal)	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	2 yrs
	(c) Anemia	2 yrs.

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized edema

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?
			m.	While at Work ☐ Not While At work ☐	

22. I hereby certify that I attended the deceased from Nov 1, 1949, to Nov 6, 1949, that I last saw the deceased alive on Nov 5, 1949, and that death occurred at ..... Am., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Thomas Reeves	M. D	Westernport, Md.	11/7/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 8, 1949	Phillips Cemetery	Westernport, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/8/49	Jannetta Boal	M. Eichhorn	Lonaconing Md

RECEIVED
NOV 29 1949
BUREAU V. S.

D. Moseley
10350

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mount Savage
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mount Savage
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Albert (Middle) Leo (Last) Logsdon

4. DATE OF DEATH (Month) Nov. (Day) 5th, (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Mch. 19, 1861
9. AGE last birthday 88 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Leo Logsdon
14. MOTHER'S MAIDEN NAME Anastasia Hogan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Leo Logsdon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Edema -

443 Antecedent cause(s)

92 b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocarditis, Mitral Insufficiency

(c) Vascular Hypertension

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cystitis with retention -

INTERVAL BETWEEN ONSET AND DEATH: 1 week; Several years; Several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1944, to Nov 5 -, 1949, that I last saw the deceased alive on Nov - 5, 1949, and that death occurred at 2:30 P. m., from the causes and on the date stated above.

SIGNATURE William E. Moseley (Degree or title) M.D. ADDRESS Mt Savage Md. DATE SIGNED November 7-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 11-8-49
NAME OF CEMETERY OR CREMATORY St. Patricks
LOCATION (City, town, or county) Mount Savage, (State) Md.

DATE REC'D BY LOCAL REG. 11-7-49
REGISTRAR'S SIGNATURE Vernon McDermott
24. FUNERAL DIRECTOR Joseph R. Duss & Frostburg Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

10351

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 30 hours; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 212 Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pa.; COUNTY: Somerset; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fairhope; STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Etta (Middle) (Last) Markwood

4. DATE OF DEATH: (Month) Nov. (Day) 17 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: June 13-1874

9. AGE last birthday: 75 yrs.

If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Fairhope Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jessie Deremer

14. MOTHER'S MAIDEN NAME: Emma Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Ester Baker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (420.1)	(a) Coronary occlusion due to	about 30 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (940)	(b) Arteriosclerosis	?
	(c) also had hypertention	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Nov. 17-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Nov. 20, 1949

NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery

LOCATION (City, town, or county) (State): Hyndman, Pennsylvania

DATE REC'D BY LOCAL REG.: Nov. 18, 1949

REGISTRAR'S SIGNATURE: Winter R. Tank. M.D.

24. FUNERAL DIRECTOR: Harvey A. Zigler, " "

ADDRESS

Zigler

RECEIVED
NOV 22 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10352

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 4 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Little Orleans
STREET ADDRESS (If rural, give location): ~~Little Orleans, Md.~~

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Edward	R.	Martin	11	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
M	W	Married	Oct 2 1877	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Carpenter	Cross Tie Inspector	Bedford Co., Pa.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Martin	Emmaline Sipes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
NO	218-01-0078	Mrs. Ethel Martin, Little Orleans, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Cerebral Thrombosis	6 wks
332 Antecedent cause(s)		
836 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	General Arteriosclerosis	2 yrs
(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Oct. 30, 1949, to Nov. 19, 1949, that I last saw the deceased alive on Nov. 18, 1949, and that death occurred at 7:37 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Nov. 21, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov 23 1949	Little Orleans Methodist Cem.	Little Orleans, Md.	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov 22, 1949	Winifred K. Beasley, M.D.	Charles R. Bast, Hancock, Maryland.	

RECEIVED
NOV 29 1949
BUREAU U. S.

Within corporate limits

Evidence for change of age shown on:

FILM No. G 123 JAN 5 1950

Arthur Jones Center St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10353

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat 54 years

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) William (Middle) [illegible] (Last) Masters

4. DATE OF DEATH: (Month) Nov. (Day) 12 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) ~~Single~~

8. DATE OF BIRTH: 1875

9. AGE last birthday: 74 ~~78~~ yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Masters

14. MOTHER'S MAIDEN NAME: Emma Gessner Masters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT: Emma Gessner, Hyndman Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary occlusion — Interval between onset and death: ½ min.

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1936, to Nov. 12, 1949, that I last saw the deceased alive on Nov. 11, 1949, and that death occurred at 5-05 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Arthur F. Jones M.D. | 110 S. Centre St. | Nov. 14, 1949

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Nov. 14, 1949 | NAME OF CEMETERY OR CREMATORY Hyndman Cemetery | LOCATION (City, town, or county) Hyndman, Pa. | (State)

DATE REC'D BY LOCAL REG. Nov. 14, 1949 | REGISTRAR'S SIGNATURE Walter R. Frantz M.D. | 24. FUNERAL DIRECTOR Harvey A. Legler, Hyndman Pa. | ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 29 1949
U. S.

DR. SIMONS

Within corporate limits

Clear Hafer when signed

10354

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 7 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 604 VIRGINIA AVENUE

3. NAME OF DECEASED (Type or Print) (First) LOUELLA (Middle) (Last) MC BRIDE

4. DATE OF DEATH (Month) 11- (Day) 24- (Year) 49

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE
8. DATE OF BIRTH JUNE 21, 1931
9. AGE last birthday 18 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME ARTHUR Mc BRIDE
14. MOTHER'S MAIDEN NAME CHRISTINE KNIPPENBURG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Lung abscess, multiple	7 yrs
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Secondary anemia	6 yrs
	(c)	

521

114d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/20, 1949, to 11/24, 1949, that I last saw the deceased alive on 11/24, 1949, and that death occurred at 8:55 A m., from the causes and on the date stated above.

SIGNATURE George M Simons M.D. (Degree or title) ADDRESS 128 Union St Cumberland, Md DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Nov. 27, 1949
NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Nov. 26, 1949
REGISTRAR'S SIGNATURE W.R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hofer ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 29 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10355

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 556 Greene St.,

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 556 Greene St.,

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) A. (Last) MEYERS

4. DATE OF DEATH: (Month) Nov. (Day) 3, (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Feb. 18, 1867	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Painter	Lonaconing, Md.	U.S.

13. FATHER'S NAME: Francis X. Meyers
14. MOTHER'S MAIDEN NAME: Mary C. Britting

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Bessie Meyers Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
149.1 Immediate cause	(a) Carcinomatosis	
53 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of L. ear	3 mo
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	None	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 10-3-49, 19..., to 11-3, 19 49, that I last saw the deceased alive on ..., 19..., and that death occurred at ... m., from the causes and on the date stated above.

SIGNATURE: C. Zimmerman (Degree or title) ADDRESS: Cumberland Md DATE SIGNED: 11-4-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 5, 1949	S.S. Peter & Paul	Cumberland, MD.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Nov. 5, 1949	Winter R. Frantz, M.D.	Charles L. George Cumberland, Md.

RECEIVED
NOV 8 1949
BUREAU V. E.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10356

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. Give correct age if especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) x 7 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PA. — COUNTY BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL BEDFORD
STREET ADDRESS (If rural, give location) RD #3 ✓

3. NAME OF DECEASED (Type or Print): (First) IVAN (Middle) DE WAYNE (Last) MILLER
4. DATE OF DEATH: (Month) NOV. (Day) 28 (Year) 1949

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: AUG 15, 1949
9. AGE last birthday: — yrs. If under 1 year: Months. 3 Days 13 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BEDFORD PA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES R. MILLER
14. MOTHER'S MAIDEN NAME: ROSE WEYANT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If year, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: JAMES R. MILLER RD#3 BEDFORD PA

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) BILATERAL BRONCHIOLAR OBSTRUCTION	10 HOURS
Antecedent cause(s)	1. PREMATURE INFANT	3 Mo 13 dys
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) 2 BILATERAL BRONCHO-PNEUMONIA	20 HOURS
	(c)	

491
107

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: NOV. 28 1949
19b. MAJOR FINDINGS OF OPERATION: TRACHEOTOMY INDICATED — TRACHEO-BRONCHIAL OBSTRUCTION BELOW TRACHEOTOMY
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) — (COUNTY) — (STATE)
TIME OF INJURY: (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from NOV 28, 1949, to NOV 28, 1949, that I last saw the deceased alive on NOV 28, 1949, and that death occurred at X m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Emmett L Jones M D — ADDRESS: 50 Pershing St Cumberland Md — DATE SIGNED: NOV 28 '49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Dec. 29, 1949 — NAME OF CEMETERY OR CREMATORY: V.O.S.M.A Cemetery — LOCATION (City, town, or county) (State): Bedford, Penna.

DATE REC'D BY LOCAL REG.: Nov. 28, 1949 — REGISTRAR'S SIGNATURE: Walter R. Mantz. M.D — 24. FUNERAL DIRECTOR: Alton Barefoot — ADDRESS: Bedford, Penna

RECEIVED
DEC 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10357

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 50 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 72 Armstrong St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 72 Armstrong St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Thomas	Francis	Miller	II- I7- 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days.	If under 24 hrs.: Hours. Min.
Male	White	Married	2-22-1863	86 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Farming	Barton, Md.	U. S. A.

13. FATHER'S NAME: Christopher Miller

14. MOTHER'S MAIDEN NAME: Jane Warnick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): Unknown

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mrs. Thos. F. Miller, 72 Armstrong Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Arteriosclerotic heart disease & congestive failure	6 mos.
420.0 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	20 yrs ±
	(c) Generalized arteriosclerosis.	20 yrs ±

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No X

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5/28, 1949, to 11/17, 1949, that I last saw the deceased alive on 11/14, 1949, and that death occurred at 7:45 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank T. Harriet	MD	59 E. Main St. Frostburg Md.	11/18/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	II-20-1949	Allegany Cemetery	Frostburg	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-20-49	Mrs. Nancy N. Rice	Jacob Hafer	Frostburg, Md.

RECEIVED
NOV 24 1949
RI BRAZIL V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10358

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Give correct age if especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): MARYLAND in route to
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Louise (Last) Moreland

4. DATE OF DEATH: (Month) Nov. (Day) 21 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Aug 18-1949

9. AGE last birthday: 0 yrs. If under 1 year: Months 3 Days 3 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -----

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul L. Moreland

14. MOTHER'S MAIDEN NAME: Grace C. Meyers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. -----

17. INFORMANT: Hospital records (old)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Lobar pneumonia (left lung)	about 3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Atelectases(left) Medialstenial shift	about 1 month
772.0 108	(c) Malnutrition	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work [ ] Not while at work [ ]
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. Nov. 21-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Nov. 23, 1949
NAME OF CEMETERY OR CREMATORY: Rose Hill Cem
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Nov. 22, 1949
REGISTRAR'S SIGNATURE: Walter R. Kautz, M.D.
24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Cumberland, Md

VS. A16A

RECEIVED
NOV 29 1949
BUREAU V. S.

10359

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

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VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; LENGTH OF STAY (In this place) 31 yrs; MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS East Main

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural, give location) East Main

3. NAME OF DECEASED (Type or Print): (First) Helen (Middle) (Last) Mundeno

4. DATE OF DEATH: (Month) Nov (Day) 28 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 13, 1918

9. AGE last birthday: 31 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Izat

14. MOTHER'S MAIDEN NAME: Marion Cuthbertson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs John Lockner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Encephalitis (non-infectious)	14 days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Dementia praecox	
300.7 / 107	(c) Broncho-pneumonia (terminal)	2 days.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pulmonary tuberculosis (Healed)	6 mo.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-26, 1949, to 11-28, 1949, that I last saw the deceased alive on 11-26, 1949, and that death occurred at 3.00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Norman Reeves, M.D. ADDRESS: Westernport Md. DATE SIGNED: 11-29-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Dec 2nd 1949

NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

LOCATION (City, town, or county) (State): Lonaconing Md

DATE REC'D BY LOCAL REG.: 12-3-49

REGISTRAR'S SIGNATURE: Jeanette M Boal

24. FUNERAL DIRECTOR: M. Eichhorn ADDRESS: Lonaconing, Md

RECEIVED
DEC 27 1949
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6 10360

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 306 Rock Street.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westernport

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport,
STREET ADDRESS (If rural, give location) 306 Rock Street.

3. NAME OF DECEASED (Type or Print) (First) Dwight (Middle) L.P. (Last) Noland.
4. DATE OF DEATH (Month) Nov. (Day) 12, (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec. 10, 1879
9. AGE last birthday 69 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter
10b. KIND OF BUSINESS OR INDUSTRY C & P RR Co.
11. BIRTHPLACE (State or foreign country) W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Elisha Noland
14. MOTHER'S MAIDEN NAME Amanda Zeiler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. 712-14-1648
17. INFORMANT AND ADDRESS Mrs. Dwight L.P. Noland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Edema of lungs	1 Day
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Angina Pectoris – Coronary Thrombosis	22 Days
	(c)	

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 20, 1949, to Nov. 12, 1949, that I last saw the deceased alive on Nov. 11, 1949, and that death occurred at 5:30 A.m., from the causes and on the date stated above.

SIGNATURE Paul R. Wilson (Degree or title) M.D. ADDRESS Piedmont, W.Va. DATE SIGNED Nov. 14, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 11/14/49
NAME OF CEMETERY OR CREMATORY Philos Cemetery
LOCATION (City, town, or county) Westernport (State) Md.

DATE REC'D BY LOCAL REG. Nov. 14/49
REGISTRAR'S SIGNATURE [illegible] M.D.
24. FUNERAL DIRECTOR Wm. Harold Fredlock Jr. ADDRESS Piedmont, W.Va

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 18 1949
BUREAU V. M.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10361

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland,
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED
~~STATE~~ Maryland — COUNTY ~~Allegany~~ District of Columbia
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ~~Cumberland~~ Washington
STREET ADDRESS: ~~1679 Southern~~ (Actual or exact location) 1st east of Southern Ave. S.E., Washington, D.C.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Margaret	Terese	Printy		Nov.	24,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Infant	Nov. 24, 1949	yrs.		28

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant		Cumberland, Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James E. Printy	E. Jeanne Geatz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Mrs. Margaret Geatz 11 S. SmallwoodSt Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Respiratory failure	
773.5 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 159	(b) Prematurity 6½-7 mos.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 24 Nov, 1949, to 24 Nov, 1949, that I last saw the deceased alive on 24 Nov, 1949, and that death occurred at 1:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Leland A Causon MD — 63 Greene St., Cumberland, Md — 25 Nov 49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 25, 1949	S. S. Peter & Paul	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 25, 1949	Winter R. Frantz, M.D.	Charles L. George	Cumberland, Md.

Ransom

RECEIVED
NOV 29 1949
BUREAU V. S.

10362

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 21st Bridge, Md. — LENGTH OF STAY (in this place) 86 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Keyser, W.Va.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural - Keyser, W.Va.	STREET ADDRESS (If rural, give location) (21st Bridge, Md.)

3. NAME OF DECEASED (Type or Print) (First) Charles	(Middle) Wesley	(Last) Ravenscroft	4. DATE OF DEATH (Month) Nov.	(Day) 3,	(Year) 1949 19
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH ,1863	9. AGE last birthday 86 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - B.& O.& W.Md.	10b. KIND OF BUSINESS OR INDUSTRY Ry. Trackman	11. BIRTHPLACE (State or foreign country) Mineral Co., W.Va.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Sabers Ravenscroft		14. MOTHER'S MAIDEN NAME Louise Dayton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. No	17. INFORMANT L.W.Dayton			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary oedema	Oct 29 '49
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocarditis · arteriosclerosis	
	(c)	

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify) none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1946, to ~~Oct~~ Nov 3, 1949, that I last saw the deceased alive on Nov 2, 1949, and that death occurred at 9 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
X Griffin	MD	Keyser W Va	Nov 3 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 11/5/49	NAME OF CEMETERY OR CREMATORY Dayton Cem.	LOCATION (City, town, or county) Allegany Co., (State) Md.
DATE REC'D BY LOCAL REG. Nov. 4/49	REGISTRAR'S SIGNATURE [illegible] MD	24. FUNERAL DIRECTOR B. W. Markwood	ADDRESS Keyser, W.Va

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 6 1949
U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10363

CERTIFICATE OF DEATH

Reg. Dist. No. 7

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — STATE Maryland
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 39
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 410 Central Ave.

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Anthony (Last) Ruppert

4. DATE OF DEATH: (Month) Nov. (Day) 4 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED: Married

8. DATE OF BIRTH: Sept 3 1879

9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10b. KIND OF BUSINESS OR INDUSTRY: Railway

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Ruppert

14. MOTHER'S MAIDEN NAME: Teresa Helmstetter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-07-9548

17. INFORMANT AND ADDRESS: Mrs Charlotte K Ruppert, Cumb'd Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 **Immediate cause** (a) Cerebro vascular Accident — Interval Between Onset and Death: 1 month

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis — 5 yr

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 3, 1949, to Nov 4, 1949, that I last saw the deceased alive on Nov 4, 1949 and that death occurred at 9:50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George M Brown M.D. — ADDRESS 128 Union St Cumberland Md. — DATE SIGNED 11/6/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE Nov. 8 1949 — NAME OF CEMETERY OR CREMATORY St. Peters & Pauls — LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Nov. 7, 1949 — REGISTRAR'S SIGNATURE Walter R. Bartz M.D.

24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS Cumberland

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10364

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 215 Franklin Street

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Schmidt

4. DATE OF DEATH: (Month) Nov. (Day) 5 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: June 6th 1861

9. AGE last birthday: 88 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): seamstress

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Allegany County, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Jos. Schmidt

14. MOTHER'S MAIDEN NAME: Magdalene Shelhaus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mrs. Barbara Ackerman, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	2 wks
Antecedent cause(s)		
450.0		
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General Arteriosclerosis	3 yrs
	(c) Senility	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from June 14, 1949, to Nov. 5, 1949, that I last saw the deceased alive on Nov. 4, 1949, and that death occurred at 4:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arthur F. Jones M.D. ADDRESS: 110 S. Centre St. DATE SIGNED: Nov. 7, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: Nov. 8 1949 NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul Cem. LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG.: Nov. 7, 1949 REGISTRAR'S SIGNATURE: Minster K. Kantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: Louis Stein, Inc. Cumberland, Md.

RECEIVED
NOV 16 1949
BUREAU V. S.

Within corporate limits

Richard Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10365

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 1313 Virginia Avenue

3. NAME OF DECEASED (Type or Print): (First) Ellen (Middle) Kennley (Last) Settle

4. DATE OF DEATH: (Month) May (Day) 16 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 15, 1877

9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Culpepper, Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Branson Settle

14. MOTHER'S MAIDEN NAME: Mildred Schackafoot

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mrs. Elizabeth Brody - 133 Grand Hve, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Thrombosis	4 days
Antecedent cause(s)	(b) Chronic Myocarditis	4 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Arteriosclerosis	4 yrs

4224 93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Jan 15, 1946, to 11/14/49, 19....., that I last saw the deceased alive on 11/16/49, 19....., and that death occurred at 9:50 a.m., from the causes and on the date stated above.

SIGNATURE: R. H. Mathews (Degree or title) MD ADDRESS: Cumberland DATE SIGNED: 11/17/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Nov. 19, 1949 — NAME OF CEMETERY OR CREMATORY: Forest Grove Baptist — LOCATION (City, town, or county) (State): Culpepper, Virginia

DATE REC'D BY LOCAL REG.: Nov. 19, 1949 — REGISTRAR'S SIGNATURE: Walter K. Kantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer, Cumberland, Md

RECEIVED
SEP 22 1949

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10366

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 603 Pine Ave.

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Carl (Last) Simmons
4. DATE OF DEATH: (Month) Nov. (Day) 24 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	married	Sept. 26-1896	53 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boilermaker	B&O.R.Ry.	Cumberland Md	U.S.A.

13. FATHER'S NAME: Floyd W. Simmons
14. MOTHER'S MAIDEN NAME: Margaret K.Spies

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes.navy	W.W.I	214-07-0220	Ethel O'Brien Simmons (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) 2nd. & 3rd. degree burns all over body	11 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

916.0
181

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	home	Cumberland	Allegany	Md.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR?
Nov.24/49-6A.m.		Pouring kerosene in sitting stove room stove

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H.V.Deming M.D.	Cumberland Md.	Nov.25-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov. 26, 1949	Greenmount Cemetery	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 26, 1949	Victor R. Hantz, M.D.	John J. Hafer	Cumberland, Md.

VS. A15A

RECEIVED
NOV 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10367

CERTIFICATE OF DEATH

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Flintstone
LENGTH OF STAY (in this place): 28 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rural Flintstone

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Flintstone
STREET ADDRESS (If rural, give location): Rural Flintstone

3. NAME OF DECEASED (Type or Print): (First) Rachel (Middle) Alice (Last) Smith

4. DATE OF DEATH: (Month) Nov (Day) 27 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Maried

8. DATE OF BIRTH: Nov 1 1877

9. AGE last birthday: 72 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: House

11. BIRTHPLACE (State or foreign country): Little Orleans, Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Martin Yonker

14. MOTHER'S MAIDEN NAME: Mary Ann Deneen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: David Smith Flintstone, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma of Breast (with	2 yrs.
170 Antecedent cause(s)		
50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) lung metastasis)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to Nov, 1949, that I last saw the deceased alive on Nov 25, 1949, and that death occurred at 905 p.m., from the causes and on the date stated above.

SIGNATURE: Benedict Satarelli (Degree or title): M.D. ADDRESS: R2 Cumberland, Md. DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify): Burial — **DATE:** Nov 30 1949 — **NAME OF CEMETERY OR CREMATORY:** Piney Plains Cemetery — **LOCATION (City, town, or county) (State):** Piney Plains, Md.

DATE REC'D BY LOCAL REG.: Nov. 29, 1949 — **REGISTRAR'S SIGNATURE:** Thos L. Benson.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

RECEIVED
NOV 30 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

10368

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) Rt. 40 West 6 mile House

3. NAME OF DECEASED (Type or Print) (First) John (Middle) William (Last) Snyder

4. DATE OF DEATH (Month) Nov. (Day) 26 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Aug 21, 1877
9. AGE last birthday 72 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Prop.
10b. KIND OF BUSINESS OR INDUSTRY Food
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY U S A

13. FATHER'S NAME Andrew Snyder
14. MOTHER'S MAIDEN NAME Catherine Glos.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS H Raymond Snyder - Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.0	Immediate cause	(a) Congestive heart failure	2 weeks
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic heart disease	2 years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 3, 1947, to Nov. 26, 1949, that I last saw the deceased alive on Nov. 25, 1949, and that death occurred at 12³⁰ A m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) M D ADDRESS 57 Greene St. DATE SIGNED 11-26-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Nov. 29 '49
NAME OF CEMETERY OR CREMATORY St Peter & Paul's Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Nov. 28, 1949
REGISTRAR'S SIGNATURE W. R. Frantz M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland Md

Stein
& Briggs

RECEIVED
DEC 3 1949
BUREAU V. S.

Rev Bring-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10369

1454 CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Oldtown; LENGTH OF STAY (in this place): 30 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, Oldtown
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ~~Route # 1,~~ Oldtown	STREET ADDRESS (If rural, give location): Route # 1.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Elmira		Sowers	November	15	19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	White	Widow	Dec 24 1864	84 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House	House	Artemas, Bedford Co, Penna	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lewis Smith	Sarah Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No	None	Mrs. John Abbott, Route 6, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure	1 doz
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic heart disease	1 yrs
	(c) Diabetes	3 yrs

260
61

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 4-1-, 1947, to 11-15, 1949, that I last saw the deceased alive on 11-2, 1949, and that death occurred at 12-55 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L Wing MD		57 Queen St.	11-15-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 17 1949	Artemas Cemetery	Artemas, Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 17, 1949	Mrs. Sue C. Dinsmore	William H. Kight, Cumberland,	Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10370

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: En route to (D.O.A.) Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: W.Va. — COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ridgely
STREET ADDRESS (If rural, give location): 25 Potomac St. ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Gary	Eugene	Tabler	Nov.	7	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	single	June 17-1943	6 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	---	Cumberland Maryland.	U.S.A.

13. FATHER'S NAME: Kenneth C. Tabler

14. MOTHER'S MAIDEN NAME: Arvella Baer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	------	Father

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

812.5 **Immediate cause** (a) Intracranial hemorrhage due to a crushed skull.

170 C **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ran against left rear wheel of a tractor-trailer truck. ~~[illegible]~~ in Ridgely, W.Va.

(c)

INTERVAL BETWEEN ONSET AND DEATH: about 5 minutes

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	highway	Ridgely	Mineral	W.Va.

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR?
Nov. 7/49-6 P.m.		Ran against left rear wheel of a T.T. truck. while crossing street.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland Md.	Nov. 7-1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 10, 1949	Rose Hill Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 10, 1949	Dexter R. Frantz, M.D.	John J. Hafer,	Cumberland, Md.

RECEIVED
NOV 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10371

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) Borden Mines

3. NAME OF DECEASED (Type or Print): (First) ROSS (Middle) F. (Last) THORP

4. DATE OF DEATH: (Month) Nov. (Day) 29, (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 11-5-1896

9. AGE last birthday: 53 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: WPA

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. Thorp

14. MOTHER'S MAIDEN NAME: Mary Kemp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): W.War 1

16. SOCIAL SECURITY No.: 220-18-2108 none

17. INFORMANT: Mrs. George Thorp

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
592 Immediate cause	(a) Uremia	1 wks.
Antecedent cause(s)		
1316 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic glomerular nephritis	1 year
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 28 Nov, 1949, to 29 Nov, 1949, that I last saw the deceased alive on 29 Nov, 1949, and that death occurred at 8 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John B. Davis, MD Frostburg Md 12/1/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 12-2-49

NAME OF CEMETERY OR CREMATORY: Allegany Cemetery

LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 12-2-49

REGISTRAR'S SIGNATURE: Mrs. Nelly H. Rice

24. FUNERAL DIRECTOR ADDRESS: J. R. Durst, Frostburg, Md.

RECEIVED
DEC 6 1949
BUREAU V. S.

Outside of City Limits

Dr. Ohj. Brings

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10372

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland — LENGTH OF STAY (in this place): 89-6-22
HOSPITAL OR INSTITUTION OR STREET ADDRESS: LaVale. - Rt 40

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland
STREET ADDRESS (If rural, give location): LaVale. Rt 40

3. NAME OF DECEASED (Type or Print): (First) Sophia (Middle) Henrietta (Last) Twigg

4. DATE OF DEATH: (Month) Nov (Day) 14 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 22 1860
9. AGE last birthday: 89 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dietrick H Lear
14. MOTHER'S MAIDEN NAME: Sophia H Hoelker.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): —
16. SOCIAL SECURITY No.: none
17. INFORMANT AND ADDRESS: C. Lear Twigg — Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

561.5 Immediate cause (a) intestinal obstruction — 6 days

Antecedent cause(s) postoperative abdominal hernia

1226 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) old age, chronic myocardial

(c) sarcoma

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 3, 1948, to 11-14, 1949, that I last saw the deceased alive on 11/13, 1949, and that death occurred at 5 30 P.m., from the causes and on the date stated above.

SIGNATURE: Ohj. Brings (Degree or title) M.D. — ADDRESS: 55 Greene St — DATE SIGNED: 11/16/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Nov 17 49 — NAME OF CEMETERY OR CREMATORY: Mt. Hermon Cem — LOCATION (City, town, or county): Rural Cumberland (State) Md

DATE REC'D BY LOCAL REG.: Nov. 16, 1949 — REGISTRAR'S SIGNATURE: Winter R. Hantz M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland Md

Mr Eliz Bungs

RECEIVED
NOV 22 1949
BUREAU V. S.

10373

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [redacted], CUMBERLAND; LENGTH OF STAY (in this place) 30 YEARS; HOSPITAL OR INSTITUTION OR STREET ADDRESS ALLEGANY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROUTE 3, CUMBERLAND, Rural; STREET ADDRESS (If rural, give location) BEDFORD ROAD

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) CATHERINE (Last) WALTERS

4. DATE OF DEATH: (Month) NOV. (Day) 7, (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: APRIL 11, 1880

9. AGE last birthday: 69 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ECKHART, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANK P. KELLY

14. MOTHER'S MAIDEN NAME: CHRISTIANA ECKHART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: JOHN WALTERS, ROUTE 3, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Thrombosis — Interval Between Onset and Death: 3 days

832 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

83b (b) Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pernicious Anemia — 1 yr

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 15, 1949 to 11/7/49 19..... that I last saw the deceased alive on 11/7/49, 19....., and that death occurred at 9 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) R. D. Williams M.D. ADDRESS Cumberland DATE SIGNED 11/8/49

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE: NOV. 10, 1949

NAME OF CEMETERY OR CREMATORY: ST. MICHAELS CEMETERY

LOCATION (City, town, or county) (State): FROSTBURG, MD.

DATE REC'D BY LOCAL REG.: Nov. 9, 1949

REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: WILLIAM H. KIGHT, CUMBERLAND, MD. ADDRESS

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS.A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10374

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 3 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va. COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgely
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Jerry (Middle) Donald (Last) Ward

4. DATE OF DEATH (Month) Nov. (Day) 5 (Year) 1949

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH Nov.15-1943

9. AGE last birthday 5 yrs. If under 1 year Months 11 Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James D.Ward

14. MOTHER'S MAIDEN NAME Margaret L. Blauch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY No. ------

17. INFORMANT Hospital record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Meningococcus meningitis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

057.0

6

INTERVAL BETWEEN ONSET AND DEATH about 3 days.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Nov.5-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Nov. 8, 1949 NAME OF CEMETERY OR CREMATORY Pinto Cemetery LOCATION (City, town, or county) Pinto, Maryland (State)

DATE REC'D BY LOCAL REG. Nov. 7, 1949 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. 24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md ADDRESS

NOV 16 1949
BUREAU V. B.

MLE Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10375

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

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T

VS. A15A

1. PLACE OF DEATH — COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 2.1/2 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: District of Columbia — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington (20) ~~D.C.~~
STREET ADDRESS (If rural, give location): 1430 S.Street Southeast.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John		Webb	Nov.	11	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	single	April 25-1943	6 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student		Jacksonville, Florida	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John S Webb Sr.	Gwendolyn E.Yelvington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	-----	G.Roy Yelvington

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Intracranial hemorrhage due to a	6 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) fractured skull from an automobile accident	
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	highway route 50	near Erwin		W.Va.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR?
Nov. 11/49 5.10 P.m.		Decending Cheat Mt. brakes burned out, unable to make a sharp turn and hit trees.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H.V.Deming M.D.	Cumberland Md.	Nov. 12-1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov. 14, 1949	Primitive Baptist Cemetery	Pinson	Fla.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 15, 1949	Winters K. Hantz M.D.	John J. Hafer	Cumberland, Md.

RECEIVED
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BY STATE W. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10376

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place): 14 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 80 Broadway

3. NAME OF DECEASED (Type or Print): (First) Lorma Ellen (Middle) (Last) Wehler

4. DATE OF DEATH: (Month) 11 (Day) 3 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 11/13/17.

9. AGE last birthday: 31 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Thomasville, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John E. Meyer

14. MOTHER'S MAIDEN NAME: Melvie Harmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: 175-10-9498

17. INFORMANT AND ADDRESS: Rev. George H. Wehler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hodgkin's Disease — Interval between onset and death: 13 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

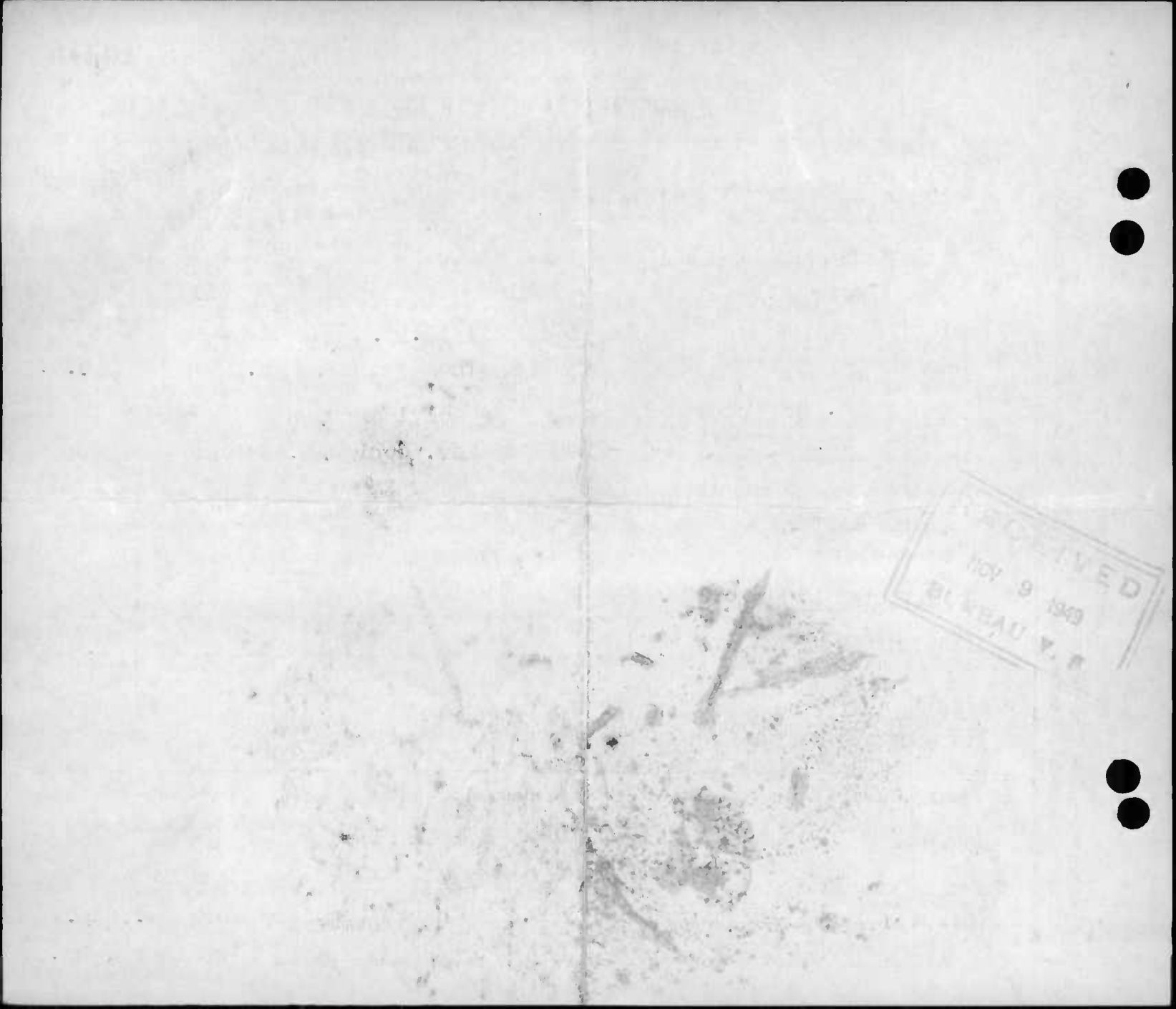
22. I hereby certify that I attended the deceased from March 10, 1944, to November 3, 1949, that I last saw the deceased alive on November 3, 1949, and that death occurred at 8:35 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Hilda Laurel Walters, M.D. — ADDRESS: Frostburg, Md. — DATE SIGNED: 11-3-49

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE: 11/5/49 — NAME OF CEMETERY OR CREMATORY: Trinity E.& R Church Cemetery — LOCATION (City, town, or county) (State): York Co., Pa.

DATE REC'D BY LOCAL REG.: 11-4-49 — REGISTRAR'S SIGNATURE: Mrs Nancy H. Roe

24. FUNERAL DIRECTOR: Jacob Hafer — ADDRESS: Frostburg, Md.


RECEIVED
NOV 9 1949
BUREAU V. R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10377

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 616 Frederick St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Pa. COUNTY Bradford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wyalusing
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Maria (Middle) E. (Last) Wells

4. DATE OF DEATH: (Month) Nov (Day) 11 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 15, 1863

9. AGE last birthday: 86 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Bradford Co. Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John L. Huffman

14. MOTHER'S MAIDEN NAME: Elizabeth Dietrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS: Mrs Robt Harris, Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) Chronic Myocarditis — Interval Between Onset and Death: 5 yrs.

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/5/49, 19..., to 11/11/49, 19..., that I last saw the deceased alive on 11/11/49, 19..., and that death occurred at 10 am m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. ADDRESS Med Bldg Cumberland Md DATE SIGNED 11/13/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Nov 15, 1949

NAME OF CEMETERY OR CREMATORY: New Era Cemetery

LOCATION (City, town, or county): New Era (State): Pa.

DATE REC'D BY LOCAL REG.: Nov. 13, 1949

REGISTRAR'S SIGNATURE: Wirta K. Frantz, M.D.

24. FUNERAL DIRECTOR: John J Hafer ADDRESS: Cumberland Md.

VS. A15

RECEIVED
NOV 22 1949
BUREAU N. M.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10378

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland, Rural
STREET ADDRESS (If rural, give location): R.F.D.#3, Box 345

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Rose	A.	Welsh	11	18	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	Single	11-15-1872	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Allegany Co. Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William H. Welsh
14. MOTHER'S MAIDEN NAME: Matilda Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: William R. Welsh. R.F.D #3. Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Congestive heart failure	1 Two
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General arteriosclerosis	3 yrs
	(c)	

450.0
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov. 7, 1949, to Nov. 18, 1949, that I last saw the deceased alive on Nov. 15, 1949, and that death occurred at 9:28 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
William F. Jones	M.D.	110 S. Centre St.	Nov. 19, 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 21 1949	Centenary Cemetery	R.F.D. #3 Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 21, 1949	Walter R. Beasley, M.D.	Louis Stein, Inc.	Cumberland, Maryland

RECEIVED
NOV 29 1949
BUREAU OF V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10379

CERTIFICATE OF DEATH

Reg. Dist. No. 12

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; LENGTH OF STAY (In this place) 2 Years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) William (Last) Williams

4. DATE OF DEATH: (Month) Nov. (Day) 12 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Dec. 16, 1914

9. AGE last birthday: 34 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operating Engineer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Wolf Summit, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Williams

14. MOTHER'S MAIDEN NAME: Marietta Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-18-1254

17. INFORMANT: Frank Williams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — Interval Between Onset and Death: 4 to 5 yrs

422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 938 (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1944, to Nov 12, 1949, that I last saw the deceased alive on Nov 12, 1949, and that death occurred at 7:30 m., from the causes and on the date stated above.

SIGNATURE John A Lapper (Degree or title) MD ADDRESS Wyndmere Pa DATE SIGNED 11-13-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Nov. 15 1949 — NAME OF CEMETERY OR CREMATORY Mt. Savage Methodist — LOCATION (City, town, or county) Mt. Savage (State) Md.

DATE REC'D BY LOCAL REG. 11-14-49 — REGISTRAR'S SIGNATURE Vernica McDermett — 24. FUNERAL DIRECTOR Harvey D. Zeigler — ADDRESS Wyndmere, Pa.

RECEIVED
NOV 17 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10380

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 26 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 424 Franklin St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 424 Franklin St.

3. NAME OF DECEASED (Type or Print): (First) Moses (Middle) Hanson (Last) Willison

4. DATE OF DEATH: (Month) Nov. (Day) 26 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Nov. 27-1867

9. AGE last birthday: 81 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Flintstone Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Willison

14. MOTHER'S MAIDEN NAME: Sarah McElfish

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Nelson willison

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) Arteriosclerosis	?

420.1
94a

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. Nov. 27-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Nov. 29, 1949 | NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | LOCATION (City, town, or county): Cumberland (State): Md.

DATE REC'D BY LOCAL REG.: Nov. 29, 1949 | REGISTRAR'S SIGNATURE: Winter K. Dantz, M.D. | 24. FUNERAL DIRECTOR: John J. Hofer | ADDRESS: Cumberland, Md.

RECEIVED
DEC 3 1949
BUREAU V. S.